

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH: COUNTY <u>Prince Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Penna</u> COUNTY <u>Phila</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75X-3</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>P. Marx</u>	(Middle) <u>Babansky</u>	(Last) <u>Babansky</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (State or foreign country) <u>Little</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Hubert</u>		14. MOTHER'S MAIDEN NAME <u>Hubert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No. <u>24</u>	17. INFORMANT <u>Peter Babansky, Sudlersville, Md.</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>450.1 Cardiac dilatation</u> Antecedent cause(s) (b) <u>General arterial sclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senility</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION <u>7-20</u>			
19b. MAJOR FINDINGS OF OPERATION <u>Pneumonia of Left Lung</u>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>72</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/20</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 20, 1953, to July 6, 1953, that I last saw the deceased alive on July 20, 1953, and that death occurred at 3:53 P.M. from the causes and on the date stated above.

SIGNATURE <u>C. R. Whitecell</u>		(Degree or title)		ADDRESS <u>Sudlersville, Md.</u>		DATE SIGNED <u>7/6/53</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>July 9</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	LOCATION (City, town, or county) <u>Madison</u>	(State) <u>Pa.</u>			
DATE REC'D BY LOCAL REG. <u>July 6</u>	REGISTRAR'S SIGNATURE <u>Edgar D. Lane</u>	24. FUNERAL DIRECTOR <u>Edgar D. Lane</u>		ADDRESS <u>Church Hill, Md.</u>			

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JUL 20 1955

BUREAU V. S.

Balkanowsky

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

Items 1,9, Film G186 9-8-55 et

1. PLACE OF DEATH: COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>8. a.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Stevensville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ezekiel</u>	(Middle)	(Last) <u>Emory</u>
4. DATE OF DEATH	(Month) <u>July</u>	(Day) <u>12</u>	(Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
9. AGE last birthday	<u>About 85</u> yrs.	10. BIRTHPLACE (State or foreign country)	11. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	<u>Farm Labor</u>	12b. KIND OF BUSINESS OR INDUSTRY	13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME	<u>Unknown</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS	<u>Luella Rich</u>	18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause		<u>Cerebral hemorrhage</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>Arteriosclerosis general + cerebral</u>	
		<u>5 years</u>	
		<u>3 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 10, 1955</u> , to <u>July 12, 55</u> , that I last saw the deceased alive on <u>July 11, 1955</u> ; and that death occurred at <u>6 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Theodor Sattelmair M.D.</u>		ADDRESS <u>Stevensville</u> DATE SIGNED <u>July 14, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>July 14, 55</u>	<u>Stevensville (Col.)</u>	<u>Stevensville</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>July 15, 55</u>	<u>Elizabeth Hostler</u>	<u>Edgar L. Lane</u>	<u>Church Hill Md</u>

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JUL 19 1955

BUREAU V. S.

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7034
Item 22 Film G184 8-9-55 ams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2520

1. PLACE OF DEATH:

County Queen Anne
City or town Centerville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Queen Anne
City or town Centerville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Mary Matilda Fisher

3.(b) Social Security Number

4. Sex Female 5. Color or race cul 6.(a) Single, married, widowed, or divorced widow
6.(b) Name of husband or wife Perry Fisher
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) June 1 - 1853
8. AGE: Years 102 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Starr md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name Joe Carter
13. Birthplace md
14. Maiden name Dont know.
15. Birthplace Dont know.

16. Informant Hewrietta Fisher (daughter)
Address Centerville md

17. Burial Date thereof July 25-55
(Burial, cremation, or removal, where?) (month) (day) (year)
Cemetery or crematory Chesterfield
Location Centerville

18. Funeral director James B. Washell
Address Exton

19. 7-23 19 55 Elie Armstrong
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 55 at 4:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 19 55 to July 22 19 55
and that I last saw her alive on July 21 19 55
Immediate cause of death Fracture of hip
resulting from a fall
Due to _____
Due to _____
Other conditions 904.0
(Include pregnancy within 8 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 4PM
Accident, suicide, or homicide Accident Date of 7-16-55
Where did injury occur? Home (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Fell in her bedroom Injured at work?

23. SIGNATURE W. Henry Fisher
Address Centerville md M. D. or other 7/23-55
Date signed

RECEIVED
AUG 3 1955
BUREAU V. S.

Items 8 & 9: Film G184
8/5/55 dmr.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chester</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		MARYLAND LENGTH OF STAY (In this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>g.a.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> TOWN <u>X</u> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (First) <u>Henry</u> (Middle) <u>Norman</u> (Last) <u>Gardner</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>12-15-1901</u> 9. AGE last birthday <u>53</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Henry Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>220-16-9956</u>		17. INFORMANT AND ADDRESS <u>Mrs. Norman Gardner - Chester</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Acute myocardial infarction</u>					<u>1 hr.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Coronary Thrombosis</u>					<u>1 hr.</u>
(c) <u>Hypertensive cardiovascular disease</u>					<u>4 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>July 13</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>July 7</u> , 19 <u>55</u> , and that death occurred at <u>8:30 A.</u> m., from the causes and on the date stated above.					
SIGNATURE <u>G. Wm. Martin, Jr. MD</u>		(Degree or title)		ADDRESS <u>Queenstown, Md.</u> DATE SIGNED <u>7/16/55</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>July 16</u>	<u>Stevensville</u>		<u>Stevensville Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS	
<u>7-16</u>	<u>Elizabeth Noyes</u>	<u>Edgar L. Lane - Church Hill, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 25 1955

BUREAU V. S.

7036
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07036
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 252...

1. PLACE OF DEATH: COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Penn</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Centerville</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>614 Penn St - Chester Penn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75X-3</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) <u>Helen Elizabeth Middleton</u>		4. DATE OF DEATH <u>July 7</u> 19 <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Nov 14 - 1914</u>
9. AGE last birthday: <u>40</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>Centerville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Wilton Daniel Sparks</u>		14. MOTHER'S MAIDEN NAME: <u>Nellie Tester</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>173-10-7357</u>	
17. INFORMANT & ADDRESS: <u>Nellie Tester Sparks - mother Centerville Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Coronary occlusion (Sudden)</u> DUE TO Antecedent cause(s) (b) <u></u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u></u>	19b. MAJOR FINDING OF OPERATION: <u></u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>W. Henry Fisher Deputy</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-7-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u></u>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>July 10 - 55</u>	NAME OF CEMETERY OR CREMATORY <u>Chester Rural</u>
LOCATION (City, town, or county) (State) <u>Chester Pa</u>	24. FUNERAL DIRECTOR <u>Barton Bros Centerville Md</u>	ADDRESS <u></u>
DATE REC'D BY LOCAL REG. <u>7-8-55</u>	REGISTRAR'S SIGNATURE <u>Oliver Armstrong</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 12 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07038

7037

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Queen Anne</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN				TOWN <u>3421-44</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)	
<u>on farm near Bennetts Pt.</u>				<u>2 a Colmd</u>	
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH	
<u>Edgar Reynolds Morris</u>				Month <u>July</u> Day <u>7</u> Year <u>1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months Days Hours Mins.
<u>male</u>	<u>col.</u>		<u>Oct 16 - 1902</u>	<u>52</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Chauffeur</u>		<u>Chauffeur</u>		<u>Balto. Md</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<u>Philip Morris</u>		<u>Marion Mc Matthew</u>		<u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
<u>no</u>		<u>no</u>		<u>Wm. V. Morris - 1527 N. Carey St</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

241X
Immediate cause

(a) Coronary Occlusion - he had asthma for last

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) 2 1/2 yrs -

He died following a heart attack while working

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

on a farm near Bennetts Pt. - 2 a Colmd

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. Henry Fisher M.D. Centerville Md Deputy Med-Exam for 2 a Colmd

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial July 7, 1955 MT. Auburn Cemetery Baltimore, Maryland
7-8-55 Wm. V. Morris Joseph L. Russ 2222 W. North Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

156

157

Route 156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07039

CERTIFICATE OF DEATH

Reg. Dist. No. 254

Item 11,12 FilmG184 8-8-55 et

1. PLACE OF DEATH- COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Hattie Ellen Poet</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 25 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 9-1875</u>
9. AGE last birthday <u>80</u> yrs.		10. under 1 year (Months) (Days) (Hours) (Min.) <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Charles B. Poet Queenstown Md</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause (a) <u>Circulatory collapse</u>			<u>2 min.</u>
Antecedent cause(s) (b) <u>Heat prostration</u>			<u>1 day.</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Myocardial insufficiency</u>			<u>6 mos.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED (While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 31</u> , 19 <u>53</u> , to <u>July 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 25</u> , 19 <u>55</u> , and that death occurred at <u>8:10 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>G.W. Martin, Jr. M.D.</u>		ADDRESS <u>Queenstown, Md.</u>	
DATE SIGNED <u>July 25, 1955</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 28-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		LOCATION (City, town, or county) (State) <u>Stevensville Md</u>	
DATE REC'D BY LOCAL REG. <u>July 28-55</u>		REGISTRAR'S SIGNATURE <u>Helen M. Aldridge</u>	
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	

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AUG 4 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7:39

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07040

CERTIFICATE OF DEATH

Reg. Dist. No. 252

Item 4. Film G184 8-9-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write OR and give nearest town) <u>Centerville</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		OR <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>MILTON</u> (Middle) <u>W</u> (Last) <u>SENEY</u>				Date: <u>July 21, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. AGE last birthday: <u>59</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Telling Station</u>		11. BIRTHPLACE (State or foreign country): <u>in Centerville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Samuel W Senev</u>				14. MOTHER'S MAIDEN NAME: <u>Fannie Kuntler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u>		16. SOCIAL SECURITY No.: <u>WW#1 217-01-1799</u>		17. INFORMANT & ADDRESS: <u>Lee Senev, Newtown Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause <u>420.1 Coronary Occlusion</u>							
Antecedent cause(s) <u>Found dead in bed</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION:			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/30</u> , 19 <u>55</u> , to <u>7/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/21</u> , 19 <u>55</u> , and that death occurred at <u>3:42</u> a.m., from the causes and on the date stated above.							
SIGNATURE <u>W. Skerry Foster M.D.</u>				ADDRESS <u>Centerville Md</u>		DATE SIGNED <u>7/22-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>July 23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		LOCATION (City, town, or county) (State) <u>Church Hill Md</u>	
DATE REC'D BY LOCAL REG. <u>7-23-55</u>		REGISTRAR'S SIGNATURE <u>Chie Armetrong</u>		24. FUNERAL DIRECTOR <u>Barton Bros. Centerville Md</u>		ADDRESS	

Forward back in back
for every document

BUREAU V. S.

AUG 3 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9, Film G184 7-22-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Queen Anne's</i>		MARYLAND		STATE <i>md.</i>		COUNTY <i>Kent</i>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <i>Barclay</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Massey</i> 14X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>08</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>JOHN O. SHELTON Sr.</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>July 14 1955</i>			
5. SEX: <i>male</i>		6. COLOR OR RACE: <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>		8. DATE OF BIRTH: <i>Aug 7, 1874</i>	
9. AGE last birthday <i>81</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Retired Farmer</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>John Shelton</i>				14. MOTHER'S M maiden NAME: <i>Elizabeth Paly</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Mrs Nelson Hill Dover Del.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Cerebral Arteriosclerosis</i>							
(C) <i>Chronic Hypertension</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Family</i>							
19A. DATE OF OPERATION: <i>no</i>		19B. MAJOR FINDINGS OF OPERATION: <i>no</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <i>no</i>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>no</i> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>no</i>			
22. I hereby certify that I attended the deceased from <i>June 22, 1955</i> , to <i>July 14, 1955</i> , that I last saw the deceased alive on <i>July 13, 1955</i> , and that death occurred at <i>837</i> M, from the causes and on the date stated above.							
SIGNATURE <i>W. A. McKittrick</i>				M. D. <i>Edgewood, Del.</i>		DATE SIGNED <i>7/15/55</i>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <i>Burial</i>		DATE THEREOF <i>July 17/1955</i>		NAME OF CEMETERY OR CREMATORY <i>Massey Cem.</i>		LOCATION (City, town, or county) (State) <i>Massey md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7-17</i>		REGISTRAR'S SIGNATURE <i>Edgar L. Rone</i>		24. FUNERAL DIRECTOR <i>Edward Nelson Millington</i>		ADDRESS <i>md.</i>	

BUREAU V. S.

JUL 20 1955

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07042

MARYLAND

STATE DEPARTMENT OF HEALTH

741

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH COUNTY <u>Queen Ann C.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Q. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Barclay P.O. Box 144</u>		STREET ADDRESS (If rural, give location) <u>P.O. Box 144</u>	
3. NAME OF DECEASED (Type or Print) <u>Johnson</u> (First) <u>de Roy</u> (Middle) <u>Wilson</u> (Last)		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX <u>M.</u> COLOR OR RACE <u>C.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	
8. DATE OF BIRTH <u>March 16, 1915</u>		9. AGE last birthday <u>40</u> yrs. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labore</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	
11. BIRTHPLACE (State or foreign country) <u>Queen Ann C. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If year, give war or dates of service) <u>W.W. II</u>		16. SOCIAL SECURITY No. <u>217-16-9295</u>	
17. INFORMANT AND ADDRESS <u>Mr. Joseph Wilson - Barclay Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>202.1</u> (a) <u>Malignant lymphoma</u>			
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>0</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 23, 1955</u> , to <u>July 16, 1955</u> , that I last saw the deceased alive on <u>July 12, 1955</u> , and that death occurred at <u>2:30 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Edgar D. Kane</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>Washington Md.</u> DATE SIGNED <u>7-18-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>July 19, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Barclay County</u> LOCATION (City, town, or county) (State) <u>Barclay Maryland</u>	
DATE REC'D BY LOCAL REG. <u>7-18</u>		REGISTRAR'S SIGNATURE <u>Edgar D. Kane</u> 24. FUNERAL DIRECTOR <u>Marion V. Waller</u> ADDRESS <u>Chesapeake Md</u>	

MARGIN RESERVED FOR BINDING

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MAR 22 1955

BUREAU V. S.